October 29, 2002

THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 10/31/02.

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-02-062

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region IV staff on this date.

Facility
Little Company of Mary Hospital
Torrance, California
License No.: 1258-19
California Agreement State Licensee

Licensee Emergency Classification
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: MISSING IODINE-125 SEEDS

DESCRIPTION:

On October 28, 2002, the California Radiation Health Branch (the Branch) notified NRC's Operations Center of the reported loss of iodine-125 sealed sources in seeds used for brachytherapy.

Little Company of Mary Hospital reported on October 28, 2002, that five iodine-125 seeds were missing after implanting sources for the treatment of prostate cancer on October 24, 2002. Each seed contained approximately 14.8 megabequerel (0.4 millicurie) of iodine-125. The licensee reported that they had received five steel tubes with ten seeds in a strip in each tube. The tubes were counted, but not opened until the procedure was initiated. Each 10-seed strip was cut in half. After implanting nine 5-seed strips, the licensee was unable to locate the tenth strip and was unable to determine if the tenth strip contained any seeds. The licensee promptly performed a radiation survey of the room and trash, but was unable to locate the missing strip. In addition, the licensee verified the number of implanted seeds by performing a fluoroscope and x-ray of the patient. A representative from Amersham was present during the procedure, but the licensee was unable to determine if the tube was shipped half empty. The licensee continued searching for the missing iodine-125 seeds and on October 28, 2002, concluded that the event was reportable. The State is monitoring licensee actions associated with this incident.

Region IV received notification of this occurrence from NRC's Operations Center on October 29, 2002. Region IV has informed OEDO, NMSS, OSTP, and the Region's PAO and SLO.

This information has been discussed with the State and is current as of 10:30 a.m. (CST) on October 29, 2002.

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